

BRIAN SANDOVAL  
Governor

Raymond E. Smith Sr.  
Executive Director

**NEVADA STATE BOARD OF EXAMINERS FOR  
MARRIAGE & FAMILY THERAPISTS AND  
CLINICAL PROFESSIONAL COUNSELORS**

9436 W. Lake Mead Blvd. Suite 11-J  
Las Vegas, Nevada 89134-3817  
Office: (702) 486-7388  
Fax: (702) 486-7258  
<https://marriage.state.nv.us>

**APPLICATION FOR CLINICAL PROFESSIONAL COUNSELORS LICENSURE**

(Type or print in ink)

Application Fee: \$75.00 check or money order made payable to: NV State Board of Examiners – MFT & CPC

**I. APPLICANT IDENTIFICATION INFORMATION:** ☐ Internship ☐ Licensure

1. Last Name	First Name	Middle Name	(Maiden)	Other Names or AKA	
2. Home Address: Street/P. O. Box/Apt.		City	State	Zip	Social Security
3. Home Phone Number		Cell Phone	Email Address		Date of Birth
4. Primary Employer		Name of Supervisor		Business Telephone/Ext.	
5. Business Address: Street/P. O. Box/ Suite.		City	State	Zip	

Preferred Mailing Address: ☐ Home ☐ Office ☐ Other Your preferred mailing address may be public information and may be placed on the Board's website and/or made available to outside organizations. If you do not want your home or work address available to the public, please provide an alternate mailing address: \_\_\_\_\_

**NAME or ADDRESS CHANGE:** It is the applicant's responsibility to notify the Board in writing of any name or address change that might occur during the application process

**PLEASE KEEP A COPY OF ALL RECORDS FOR YOUR FILE.**

NAC 641A gives the Board the right to refuse to issue, suspend or revoke any registration, permit or license, of any licensee or applicant if the candidate secures the license, registration or permit by fraud, deceit or misrepresentation on any application for licensure submitted to the Board. Please review NRS 641A and NAC 641A from the website <http://marriage.state.nv.us> at the "About Us" page.

Disclosure of your social security number is mandatory pursuant to 42 U.S.C. §666(a)(13) and will be used for tax enforcement purposes, may be used for child support enforcement purposes or may be provided to a licensing or examination entity which uses a national examination for purposes of verification of license or examination status.

**II. GENERAL INFORMATION:**

- Are you a citizen of the United States? Yes \_\_\_\_ No \_\_\_\_
- Are you lawfully entitled to remain or work in the U.S.? Yes \_\_\_\_ No \_\_\_\_ Alien Registration Number \_\_\_\_\_
- Have you ever filed an application for licensure or registration in Nevada? Yes \_\_\_\_ No \_\_\_\_ If yes, please answer the following:
  - Which Credential: \_\_\_\_\_ When: \_\_\_\_\_  
Under what name: \_\_\_\_\_ State/Number: \_\_\_\_\_
  - Which Credential: \_\_\_\_\_ When: \_\_\_\_\_  
Under what name: \_\_\_\_\_ State/Number: \_\_\_\_\_
- Do you currently hold, or have you ever held a license, certificate or registration to practice clinical professional counseling in another state or jurisdiction? Yes \_\_\_\_ No \_\_\_\_ If yes, please answer the following questions:
  - Which Credential: \_\_\_\_\_ When: \_\_\_\_\_  
Under what name: \_\_\_\_\_ State/Number: \_\_\_\_\_  
Which state or jurisdiction: \_\_\_\_\_
  - Which Credential: \_\_\_\_\_ When: \_\_\_\_\_  
Under what name: \_\_\_\_\_ State/Number: \_\_\_\_\_  
Which state or jurisdiction: \_\_\_\_\_
- What is your qualifying Master's degree?: \_\_\_\_\_ Degree Credits: \_\_\_\_\_
- Name of School, College, University or Institution: \_\_\_\_\_

**III. EXAMINATION:**

- A. If you have not previously taken the National Clinical Mental Health Counseling Examination developed by the National Board for Certified Counselors and achieved a passing score, you will be notified in writing when you will be eligible to register and sit for the examination. Applicants must first satisfy the Nevada State educational requirements and obtain a license in order to be authorized by the Board to register for the examination.

- B. Did you complete the National Clinical Mental Health Counseling Examination through this Nevada State Board office?  
Yes \_\_\_ No \_\_\_ If you answered "no", please provide the following:

Name of the state in which you took the National Clinical Mental Health Counseling Examination (Contact the National Board for Certified Counselors to transfer your official score to Nevada and send an official copy of your score directly to the Board office.)

Date exam was taken: \_\_\_\_\_ State/Location of Exam: \_\_\_\_\_

---

**IV. BACKGROUND INFORMATION**

1. Have you ever been arrested, charged with, or convicted of, or plead guilty or nolo contendere to any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense? Please note driving or being in control of a motor vehicle while under the influence of any chemical substance, including alcohol, is not considered a minor traffic offense.  
Yes \_\_\_\_\_ No \_\_\_\_\_
2. Have you ever had a complaint filed with a certifying, licensing, or registering body or any professional association against you for alleged unethical behavior or unprofessional conduct?  
Yes \_\_\_\_\_ No \_\_\_\_\_
3. Have you ever been censured or had any disciplinary action taken against you for unethical behavior, unprofessional conduct or any other grounds by any certification or licensing board or other agency, institution, or professional organization?  
Yes \_\_\_\_\_ No \_\_\_\_\_
4. Have you ever been investigated, charged with, or convicted of unprofessional conduct, negligence, or professional incompetence by any certification or licensing board or other agency, institution, or professional organization?  
Yes \_\_\_\_\_ No \_\_\_\_\_
5. Have you used any alcohol, narcotic, barbiturate other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent within the last 5 years?  
Yes \_\_\_\_\_ No \_\_\_\_\_
6. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?  
Yes \_\_\_\_\_ No \_\_\_\_\_
7. Have you used controlled substances which were obtained illegally or which were not obtained pursuant to a valid prescription order or which were not taken following the direction of a licensed health care provider within the past 5 years?  
Yes \_\_\_\_\_ No \_\_\_\_\_
8. Has any state, jurisdiction, province, or professional organization denied your application for credentials or professional membership?  
Yes \_\_\_\_\_ No \_\_\_\_\_
9. Have you ever been named as a defendant or have been requested to respond as a defendant to a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself?  
Yes \_\_\_\_\_ No \_\_\_\_\_

**IF ANY OF THE ABOVE QUESTIONS HAVE BEEN ANSWERED "Yes," please explain the circumstances and outcome on the reverse side.**

---

**V. ACADEMIC REQUIREMENTS:**

- A. I am submitting official transcripts verifying having met the academic requirements as indicated (select one by initialing the appropriate line.)

\_\_\_ A graduate degree in mental health counseling or community counseling from a program accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP)

\_\_\_ An acceptable graduate degree as determined by the Board which includes completion of a practicum and internship in mental health counseling which was taken concurrently with the degree program and was supervised by a licensed mental health professional as described in NRS 641A.

Please print or type clearly giving an accurate record of your educational preparation below. YOU MUST COMPLETE ALL INFORMATION FOR ALL SCHOOLS/COLLEGES/UNIVERSITIES/INSTITUTIONS ATTENDED AND DEGREES RECEIVED OR YOUR APPLICATION WILL BE CONSIDERED INCOMPLETE. (You may attach additional sheets, if necessary.)

**B. Undergraduate Education:**

Name of School	Address	City	State	Country
Title of Degree (In the original language)	Date Awarded	Major	Attendance From	To

**C. Graduate Education in Clinical Professional Counseling:**

Name of School	Address	City	State	Country
Title of Degree (In the original language)	Date Awarded	Major	Attendance From	To

**D. Other Graduate Study:**

Name of School	Address	City	State	Country
Title of Degree (In the original language)	Date Awarded	Major	Attendance From	To

**E. Required Areas of Study:**

1. Human Development, including Issues of Sexuality: (minimum 1 course; 3 semester hrs or 4 quarter hrs.)  
Course Title (as appears on Transcript) Course Number Credit Hours

2. Individual Counseling Theories: (minimum 1 course; 3 semester hrs or 4 quarter hrs.)  
Course Title (as appears on Transcript) Course Number Credit Hours

3. Individual Counseling Techniques and Practices: (minimum 1 course; 3 semester hrs or 4 quarter hrs.)  
Course Title (as appears on Transcript) Course Number Credit Hours

4. Lifestyle and Career Development: (minimum 1 course; 3 semester hrs or 4 quarter hrs.)  
Course Title (as appears on Transcript) Course Number Credit Hours

5. Group Dynamics Counseling and Consulting: (minimum 1 course; 3 semester hrs or 4 quarter hrs.)  
Course Title (as appears on Transcript) Course Number Credit Hours

6. Ethics and Professional Studies: (minimum 1 course; 3 semester hrs or 4 quarter hrs.)  
Course Title (as appears on Transcript) Course Number Credit Hours

7. Supervised Clinical Practice in CPC: (minimum 3 courses; 9 semester hrs or 12 quarter hrs over a calendar year)  
Course Title (as appears on Transcript) Course Number Credit Hours

---

---

---

8. Diagnosis and Assessment: (minimum 1 course; 3 semester hrs or 4 quarter hrs.)  
(including the use of the Diagnostic and Statistical Manual)  
Course Title (as appears on Transcript) Course Number Credit Hours

---

9. Social and Cultural Foundations: (minimum 1 course; 3 semester hrs or 4 quarter hrs.)  
Course Title (as appears on Transcript) Course Number Credit Hours

---

10. Research and Evaluation: (minimum 1 course; 3 semester hrs or 4 quarter hrs.)  
Course Title (as appears on Transcript) Course Number Credit Hours

---

11. Abuse of Alcohol or Controlled Substances: (minimum 1 course; 3 semester hrs or 4 quarter hrs.)  
Course Title (as appears on Transcript) Course Number Credit Hours

---

---

## **VI. SUPERVISED CLINICAL EXPERIENCE:**

### **A. Requirements for licensure as a CPC:**

1. Before an applicant is eligible for licensure as a clinical professional counselor, he must complete at least 3,000 hours of experience in an approved internship. The requirements, found in NAC 641A.146, include:
  - a. At least, 1,500 hours of direct contact with clients in the practice of clinical professional counseling.
  - b. At least 100 hours of clinical professional counseling supervision by the approved primary or secondary supervisor of the intern. See NAC 641A.146(3)(b)(1) and (2) for additional requirements.
  - c. At least 1,200 hours of work related to the practice of clinical professional counseling. See NRS 641A.146(3)(c)(1), (2), (3), (4) and (5) for additional requirements.

An applicant who is currently licensed and in good standing as a clinical professional counselor in another state or jurisdiction may be eligible for licensure, contingent upon meeting Nevada requirements. A Nevada Verification of License Form\* should be sent to each licensing body to be returned directly to the Board office from each licensing body. The Board may accept, deny or grant partial credit for requirements completed in another jurisdiction. Supervision completed toward licensure as a clinician other than a clinical professional counselor is not eligible to be used toward licensure as a licensed clinical professional counselor.

If you are licensed in another state as a clinical professional counselor, please provide a copy of the following:

- \_\_\_\_\_ License
- \_\_\_\_\_ Verification of License Form\* (Have each licensing agency send this form to the Board office.)
- \_\_\_\_\_ Official Licensing examination score (Have the examining agency send your official score to the Nevada Board office.)
- \_\_\_\_\_ Experience Verification Form\* - Documentation of supervision and/or supervised experience.

\* Verification of License Form found on the Licensing Information Page of the website: <http://marriage.state.nv.us>.

Please List all professional licenses or certifications that you have held within the last 10 years.

Professional License Held/Expiration Date	Issuing Board/State	License Number	Issuing Date
---	---------------------	----------------	--------------

Professional License Held/Expiration Date	Issuing Board/State	License Number	Issuing Date
---	---------------------	----------------	--------------

## VII. APPLICANT'S ATTESTATION:

- A. I have reviewed the licensure eligibility requirements prior to submitting this application. Yes \_\_\_ No \_\_\_
- B. I have completed the application materials and procedures honestly and in good faith. Yes \_\_\_ No \_\_\_
- C. I understand that the members and staff of the Board are compelled by law to uphold, implement and enforce the licensure statutes and regulations as written. Yes \_\_\_ No \_\_\_
- D. I understand that the Board has the statutory authority to refuse to grant licensure to, or may suspend, revoke, condition, limit, qualify, or restrict the license of any individual that has knowingly made a false statement on a Nevada State form required for licensure or licensure renewal. Yes \_\_\_ No \_\_\_
- E. I have read and am familiar with the statutes and regulations governing the practice of clinical professional counseling in Nevada. Yes \_\_\_ No \_\_\_
- F. I understand that once the Board receives my application I am bound by, and will abide by the statutes and regulations governing the practice of marriage and family therapy in Nevada. Yes \_\_\_ No \_\_\_

## VIII. CHILD SUPPORT STATEMENT

Nevada state law requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. As part of this application, your responses to these questions are given under oath and any response given hereto which is false, fraudulent, misleading, inaccurate or incomplete, will result in your application being denied. You must mark one of the following responses. Failure to indicate which provision applies will result in your application being denied.

I am not subject to a court order for the support of a child.

I am subject to a court order for the support of one or more children and am in compliance with an order or am in compliance with a plan approved by the district attorney or other public agency enforcing an order for the repayment of the amount owed pursuant to the order.

I am subject to a court order for the support of one or more children and am **NOT** in compliance with an order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

## IX. AFFIDAVIT

I agree to allow the Board of Examiners for Marriage & Family Therapists and Clinical Professional Counselors ("Board") to communicate with any person in connection with this application. I will hold the Board, its members, officers, and agents free from any liability or complaint by reason of any action any of them may take in connection with the Board's investigation of my professional training, experience, or personal and professional background.

The undersigned hereby applies for a license, under the laws and regulations governing clinical professional counselors and certifies under penalty of perjury that all statements contained herein are true and correct to the best of his/her knowledge and belief; that he/she is the person named in the credentials submitted, and the same were procured in the regular course of instruction and examination, without fraud or misrepresentation; and with full knowledge that all statements made in this application may be subject to investigation, including a check of fingerprints, police records, and former employers. I understand that if any of my responses on this application are false, fraudulent, misleading, inaccurate or incomplete, my application will be denied.

Signature

Date

## X. FINGERPRINTING AND BACKGROUND CHECK

Using black ink, fill in the boxes on the top half of the cards (SSN, sex, race, height, etc.) and sign where indicated. It is recommended that you go to a police precinct and use their fingerprinting department. Have the Officer note any scars on the fingerprint area or any other irregularities, such as missing digits, etc. You do not have to be fingerprinted in Nevada. You are encouraged to start this process immediately as results may take 6-12 weeks. Send your 2 completed fingerprint cards, a complete copy of your Driver's License and the certified check or money order for \$48.50 payable to **Department of Public Safety**, to the Board office along with your application or separately from your application. **(Please, no personal checks accepted for the background check.)**

Mail Application to NV State Board of Examiners – MFT & CPC, P.O. Box 370130, Las Vegas Nevada 89137